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RESPONSE OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO THE NATION'S EMERGENCY CARE CRISIS

Friday, June 22, 2007

House of Representatives,

Committee on Oversight and

Government Reform,

Washington, D.C.

Committee Hearings

of the

U.S. HOUSE OF REPRESENTATIVES

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The committee met, pursuant to call, at 10:02 a.m., in Room 2154, Rayburn House Office Building, Hon. Elijah E. Cummings presiding.

Present: Representatives Cummings, Davis of Virginia, Platts, Issa and Jordan.

Staff Present: Phil Barnett, Staff Director and Chief Counsel; Karen Nelson, Health Policy Director; Karen Lightfoot, Communications Director and Senior Policy Advisor; Andy Schneider, Chief Health Counsel; Molly Gulland, Assistant Communications Director; Steve Cha, Professional

Staff Member; Earley Green, Chief Clerk; Teresa Coufal, Deputy Clerk; Caren Auchman, Press Assistant; Art Kellerman, Fellow; David Marin, Minority Staff Director; Larry Halloran, Minority Deputy Staff Director; Susie Schulte, Minority Senior Professional Staff Member; Brian McNicoll, Minority Communications Director; and Benjamin Chance, Minority Clerk.

Mr. CUMMINGS. [presiding.] This committee will come to order. Today's hearing is regarding access to emergency care. Without objection, the Chair and Ranking Minority Member will have 5 minutes to make opening statements, followed by opening statements not to exceed 3 minutes by any other committee member who seeks recognition.

I will remind the committee members that it is anticipated that we will be out of here by 12:00, so we are going to stick strictly to our rules.

With that, I want to thank all of you for being here, and today we will examine the response of the Department of Health and Human Services to the Nation's emergency care crisis. In times of tragedy Americans rely on our emergency care system. Whether because of a car wreck, heart attack, stroke or pregnancy complication, Americans and their families show up at the doorstep of our Nation's emergency rooms seeking critical care every day.

Emergency care is the great equalizer. It is the only form of health care guaranteed to every American, regardless of his or her ability to pay. But in this way it also provides a chilling snapshot of what is wrong with our Nation's health care system.

We all want emergency care to work effectively for ourselves and for our loved ones. When it does work, and it usually does, by the way, lives are saved, lifelong

disability is avoided. The many dedicated men and women who staff our Nation's ERs, trauma centers and ambulance services deserve our appreciation and our support.

But when the system fails, it can have fatal consequences. Earlier this week USA Today carried a front-page story on the health crisis in Houston where ERs divert ambulances 20 percent of the time. One doctor described the patient who died after being diverted from a Houston area hospital to one in Austin 1,600 miles away, and I quote, he said, diversion kills you.

In my hometown of Baltimore, our city health department study documented that between 2002 and 2005 the total hours city hospitals were on red alert status, meaning that they had no cardiac-monitored beds for arriving ER patients, increased by 36 percent; the length of time it took ambulances to offload patients in the ER increased by 45 percent; and the number of hours ambulances were diverted from over crowded ERs shot up by 165 percent. Unfortunately, the emergency care crisis is not limited to Houston, and certainly not limited to Baltimore.

Failures in the ER have led to an increase in preventable death from treatable conditions like heart disease. An article in this morning's edition of USA Today indicates that seven of our Nation's hospitals have worse heart attack death rates than the national average, while 35

have higher death rates for heart failure.

The L.A. Times reported this past May that a 40-year-old woman collapsed on the waiting room floor of the ER at Martin Luther King-Harbor Hospital in Los Angeles while janitorial staff literally mopped the floor around her. Overburdened staff ignored her pleas for help, and her boyfriend, desperate for assistance, dialed 911 from the hospital. He was told to find a nearby nurse. His girlfriend died 45 minutes later.

Last month Newsweek.com described the critical challenges facing Grady Memorial Hospital in Atlanta. Grady Hospital supports one of the busiest ERs in the State and the only Level I trauma center in a metropolitan area of 5 million people. On any given day it is not unusual for eight Atlanta hospitals to be diverting patients at the same time. What will Atlanta do if Grady closes its ER?

Even here in the District of Columbia it is not unusual for ambulances to be parked seven deep in front of one or more of the city's bigger ERs waiting to offload patients. Not to be too blunt, but these are the same ERs that members of Congress and our families would turn to in an emergency.

The fact of the matter is that we have a crisis in emergency care, and it is nationwide. This begs the question, with the national emergency and trauma care system as fragile as ours, how will we manage the real threats of a

terrorist bombing, a natural disaster, or an outbreak of pandemic flu? Where is the surge capacity?

The emergency room crisis is nothing new. More than 5 years ago, U.S. News and World Report published a cover story entitled crisis in the ER: Turnaways and delays Are a Recipe For Disaster. A copy is displayed on the easel before me.

If you look closely, you will note, ironically, that the issue was published on September 10th, 2001. Five weeks after September 11th, Chairman Waxman released a report detailing the national problem of ambulance diversions and the shortage of emergency care. His report identified over 20 States in which hospitals were turning away ambulances because of overcrowding and funding shortfalls. Subsequent reports reached similar conclusions. A 2003 report by the Centers for Disease Control and Prevention found that ER rooms in U.S. hospitals diverted more than 1,300 patients a day, 1,300 patients a day, 365 days per year. A 2003 GAO report documented ER crowding throughout the country.

One year ago the Institute of Medicine of the National Academy of Sciences released a three-volume report on emergency care in the United States health system. This landmark study concluded that our Nation's emergency and trauma care system is at the breaking point.

Last summer Congress enacted the Pandemic and All Hazards Preparedness Act. This act assigned responsibility

for leading all Federal public health and medical responses to public health emergencies to the Department of Health and Human Services, but despite this clear responsibility, and despite the billions of taxpayers' dollars that Congress has appropriated for biodefense and pandemic preparedness, HHS appears to be ignoring the mounting emergency care crisis.

The Department has not made a serious effort to identify the scope of the problem, which communities are most affected. It has failed to require hospitals that participate in Medicare to report data on the extent of ER boarding and ambulance diversion. It has failed to use its purchasing power through the Medicare program to encourage hospitals to properly admit ill and injured patients to inpatient units rather than boarding them in ER hallways and forcing staff to divert inbound ambulances. It has done nothing to promote the regionalization of highly specialized trauma and emergency care services, a key recommendation of the IOM report.

Worse yet, the Department has recently taken some actions that will make matters worse. It is undisputed that part of the emergency care crisis is a result of the historic underfunding of safety net hospitals, many of which serve as cornerstones of trauma and emergency care systems in their communities. However, rather than asking Congress for additional resources to assist these hospitals, the

Department has attempted to bypass Congress by issuing rules that would cut hundreds of millions of dollars in supplemental Medicaid funding from these facilities.

Ladies and gentlemen, this simply makes no sense. Last month the Congress enacted a 1-year moratorium that blocks the Department from implementing these funding reductions, but HHS has shown no signs of modifying its position.

Today we will hear from leading private-sector experts on emergency care, trauma care and ambulance services. They will describe the emergency care crisis from the front lines. We will also hear from representatives of two agencies with HHS that have a particularly important role to play in addressing the crisis, the Office of the Assistant Secretary for Preparedness and Response and the National Institutes of Health.

I hope that the testimony we hear today will help provide our committee with an understanding of the emergency care crisis that confronts us all. Nearly 6 years have passed since the wakeup call of September 11th, and HHS has yet to tackle this problem. The time for action is long overdue.

With that I yield to the distinguished Ranking Member of the full committee Mr. Davis.

[Prepared statement of Mr. Cummings follows:]

******** INSERT 1-1 ********

Mr. DAVIS OF VIRGINIA. Thank you very much. I want to thank Chairman Waxman for initiating this hearing. It is a very timely issue. We all know the value of a functioning emergency room. Millions of lives are saved annually only because emergency care is available.

But across America it is critical care services that are in critical condition. Last year a study by the Institute of Medicine, the IOM, concluded our hospital-based emergency medical system was at the breaking point. Emergency rooms are finding it impossible to meet growing and competing demand for trauma care, mandated safety net care for the uninsured, public health surveillance, and disaster readiness.

The IOM panel found emergency care capacity suffering from an epidemic of crowding, with patients parked or boarding in hallways waiting to be admitted. Ambulances were routinely diverted to more distant facilities.

While demand for EMS facilities grows, the number of facilities shrinks, and they still find it increasingly difficult to retain on-call specialists to meet standards for timely care. The inevitable tragic result: preventable deaths as critically ill patients literally die from neglect in hallways and in ambulance space waiting for the lifesaving help that never comes.

The simple truth is emergency care can and should be

better, but it is the legal, financial and demographic trends that have converged to punish the success of hospital emergency departments transformed by Federal law into a de facto primary care provider for millions of under- and uninsured Americans. That unfunded mandate creates powerful incentives to close emergency rooms or limit admissions so that capacity to perform elective, fully reimbursed procedures will not be reduced.

Low reimbursement rates and high malpractice premiums also work to keep needed specialists, neurosurgeons, orthopedic surgeons and pediatricians, among others, from taking emergency and trauma patients.

The anemic state of emergency medical services means most hospital centers are already operating at or near capacity every day. A highway crash involving multiple casualties can overwhelm not just one, but all nearby hospitals because no one has information about the real-time availability of emergency beds in the region.

Such a fragile fragmented system holds virtually no surge capacity in the event of a natural disaster or terrorist attack. This committee has held several hearings on pandemic planning and preparedness. A constant concern that emerged from those hearings was the lack of surge capacity in our Nation's hospitals.

We have made great strides in homeland security since

9/11, but our public health infrastructure, particularly emergency medical response capacity, is still not ready for prime time. When the influenza pandemic erupts, as many predict it will, more than half a million Americans could die, and over 2 million could need to be hospitalized.

How do we plan to move from the current inadequate emergency care structure to the coordinated, regionalized, scalable and transparent system that we know that we need? What is the Federal role in building and sustaining affordable and efficient medical services? How can we link emergency care capacity into a national response network to meet the full range of critical care demands from the predictable to a pandemic?

I look forward to a discussion with our witnesses today on these difficult questions. I am especially pleased to welcome Dr. Robert O'Connor, professor and chairman of the department of emergency medicine at the University of Virginia. He is widely regarded as one of our Nation's leading EMS physicians, and we are very grateful for his time and insights as we explore these urgent issues. Thank you.

Mr. CUMMINGS. Thank you, Mr. Davis.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. CUMMINGS. It is my understanding that Ms. Watson has an opening statement. Ms. Watson, you are recognized for 3 minutes.

Ms. WATSON. Thank you, Mr. Chairman, for holding today's hearing. It is so relevant to constituents in my district in Los Angeles, the 33rd District.

We are going through a very serious crisis in our emergency care system. A functional emergency and trauma care system is important for all communities to deal with and respond to disasters, and we must remember that these emergency care centers are not only for those patients who use them on a day-to-day basis, but they are what our Nation will rely on if a natural disaster or terrorist attack occurs.

This sector of the health care system is one of the most important aspects of our homeland security. As pointed out in the Majority memo on May 9th, 2007, you heard about the 40-year-old woman who collapsed on the waiting room floor at Martin Luther King Hospital, and her pleas for help were ignored, and she died 45 minutes later.

This hospital serves a major portion of my constituency who have no insurance and who do not have access to any other means of health care. This incident was not the only one reported at the former King/Drew Hospital, and definitely not the only occurrence in many emergency rooms across the

Nation. What are we showing the world by letting our citizens die in emergency rooms in the wealthiest Nation in the world?

The three Federal departments, DOT, DHS and HHS, that are responsible for the oversight of emergency and trauma care must start working together to make the system work better, and I am sure there is along list of oversight errors and omissions that point to the core of many of the problems we are discussing today. I hope that by addressing this issue it is not too little and not too late.

Hospitals in our Nation's urban areas have been plagued for years. They have been underfunded for so long that they cannot attract the type of doctors and nurses they need to run a high-quality hospital, and, in turn, due to poor reputation, you limit the number of talented health care professionals you attract, creating a downward spiral.

Mr. Chairman, having hospitals such as King-Harbor in my community, even in the condition it is in, is better than not having a hospital at all. The risk of getting inadequate health care is outweighed by the potential loss from having to drive an extra 20 minutes to get care at any other hospital, leading to overcrowding at those other hospitals.

So I am looking forward to hearing from the witnesses, and I hope that we can get some answers so that we can remove the many risks that accrue to our public.

Thank you so much, Mr. Chairman.

Mr. CUMMINGS. Thank you, Ms. Watson.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. CUMMINGS. What we will do now, without objections, we will recess because we have two votes. We have about 5 minutes left for the first vote, and then another vote will come immediately thereafter. I anticipate that we should be back here at quarter of the hour. Until then, we will recess.

Thank you, witnesses, for being patient with us. We will move this along as fast as we can. Thank you.

[Recess.]

Mr. CUMMINGS. Thank you all for waiting. We will resume the hearing now.

The committee will now receive testimony from the witnesses before us today. Our first panel consists of three distinguished experts in the emergency trauma care. Dr. William Schwab is professor and chief, division of traumatology and surgical critical care at the University of Pennsylvania Medical Center in Philadelphia. Dr. Ray Johnson is associate director of the department of emergency medicine, Mission Hospital Regional Medical Center, and director of pediatric emergency medicine, Children's Hospital, Mission Viejo. And Dr. Bob O'Connor is professor and chairman, department of emergency medicine, University of Virginia, Charlottesville.

Gentlemen, would you please stand to be sworn in.

[Witnesses sworn.]

Mr. CUMMINGS. I just remind you that we have your statements, your written statements, and we would just ask you to summarize within 5 minutes if you can. Then we will have questions.

Dr. Schwab.

STATEMENTS OF WILLIAM SCHWAB, M.D., FACS, PROFESSOR AND CHIEF OF DIVISION OF TRAUMA AND SURGICAL CRITICAL CARE, UNIVERSITY OF PENNSYLVANIA MEDICAL CENTER, PHILADELPHIA; RAMON JOHNSON, M.D., FACEP, ASSOCIATE DIRECTOR, DEPARTMENT OF EMERGENCY MEDICINE, MISSION HOSPITAL REGIONAL MEDICAL CENTER, DIRECTOR OF PEDIATRIC EMERGENCY MEDICINE, CHILDREN'S HOSPITAL, MISSION VIEJO, CALIFORNIA; AND BOB O'CONNOR, M.D., MPH, PROFESSOR AND CHAIRMAN, DEPARTMENT OF EMERGENCY MEDICINE, UNIVERSITY OF VIRGINIA, CHARLOTTESVILLE, VIRGINIA

STATEMENT OF WILLIAM SCHWAB

Dr. SCHWAB. Thank you, Congressman. I think rather than try to summarize, what I might do is start with a bit of a story, since it is a relatively recent story and something that is very pertinent to the IOM report.

I sat for 2-1/2 years as one of the 40 members of the IOM Commission and spent a considerable amount of time actually deliberating, analyzing and trying to come up with solutions, both tactical and strategic, to look at this crisis in emergency care, but perhaps this story more than anything will make it real for you.

Just 2 days ago I was not on call for emergency. There

is a group of nine of us at the University of Pennsylvania, surgeons that do all the emergency surgery and all the trauma care. We are a Level I trauma center, we are one of the safety net hospitals, and we are one of the hospitals that in a disaster for the greater Philadelphia area for a population of about 15 million people we would go into action.

2:30 in the afternoon, just a normal day, I had a call from my fourth partner, not on call, to go to the emergency department to run a fifth room. I walked down to the emergency department and walked through our unit, and in that emergency department there were people everywhere on stretchers, there were patients in chairs. The emergency physicians, our strongest colleagues and friends, were administering to people.

And this wasn't a mass disaster, this was a fairly typical day with the exception that we had just been notified that, in fact, on Route 95 there was a significant crash, probably a few mortally wounded, and other people being brought in by helicopter and by ambulance.

I went into our trauma center, very similar to that in Nashville or that in Baltimore, and I responded to what is a three-bed unit, had five people in it, two people on stretchers that were side by side with other people. And as we started to take care of these patients coming in from this terrible wreck and this collision, we had 30 seconds' warning

that the Philadelphia Fire Department was bringing in yet another person, and that was a trauma code. It was a young man that had received a gunshot wound. And in the middle of that mayhem I opened his chest, and I started to pump his heart, and I tried to resuscitate him.

Now that is all part of our life in this business, but what is interesting is I looked up and I recognized that I was doing that, and 40 feet away from me watching me were those people brought in for routine care and other emergencies.

What was most interesting about this is you might say that is just Philadelphia, it is a big city, and it is like any other city, Los Angeles or Washington, Atlanta. But that morning I had been on the phone thanking someone at Strong Memorial Hospital in Rochester, New York, because last week my brother-in-law, 63-year-old retired teacher, an All-American football player in his prime who had lost his kidneys a few years ago to a terrible infection, and a renewal dialysis patient for years, had just been transplanted, was home, became ill, went back to Strong Memorial and could not be admitted because the ED had 40 or 50 people waiting to be admitted in Upstate New York, where I grew up in beautiful downtown Rochester.

I couldn't believe it. But having spent 2-1/2 years on the IOM and trying to find solutions for this government and

for us to take on emergency, you have to believe it. It is universal, it is a terrible problem, it is a hidden problem. It has been swept underneath the rug continuously, and it may be being swept under the rug because people believe there is no good way to solve it, and the only way to solve it is throw money at it. I will tell you the IOM did not conclude that, and our recommendations came after some thousands of hours of deliberation and looking at things.

I have to also tell you that as I walked through the emergency department, I saw teams of specialists down there, cardiology, neurology, but the one that really frightened me was I saw infectious disease. And a friend of mine in the infectious disease department is a virologist, virus expert. And I finished with the emergency thoracotomy, and I was walking out to do my paperwork, and I thought of all the things I am afraid of, what I am afraid of the most is that virologist was seeing something, and it was a virus, and that was sitting in the middle of our emergency department with all those hundreds of people.

There is no way that simple solutions will fix this. This is going to take some concerted effort.

I would like to end by saying that I am absolutely shocked that there hasn't been more done in the last year, even just simple communication about how we could help our government agencies and we can partner as health care,

medicine and nursing to help fix this.

We do need to look at better coordination from the government. We truly believed in the Institute of Medicine and in our committee that it was spread out to too many agencies. There is no one agency that is responsible, there is no champion for emergency care. We believe that the whole system had to be looked at, and we believed that there had to be substantial thought, redesign and reengineering not of the system, but of things like why patients wind up in the emergency department when they could go to primary care.

We felt that we needed to look at making hospitals and EMS systems accountable. We just weren't going to make recommendations to you from the Institute of Medicine that said, do this for us, we want to make this system accountable. And we looked for one of the best successes in medicine to fix it, and that was the trauma system.

The trauma systems have been a around for about 30 years. They actually come from the experience we had during Vietnam, and that military system was transformed and translated into civilian care systems. Trauma systems are regionalized, they are accredited, they are credentialed, and they are accountable because they report their results to the public and to the government. The Institute of Medicine in its interdisciplinary committee put this at the center of the committee report, to redesign emergency care based on

regional systems that are accountable, and they report their outcome. I think that is an important thing.

Last, there were two things that came about during the 2-1/2 years that I served in the Institute of Medicine that I think you are aware of. One you are very aware of, and that is the inability of the health care system and specifically the emergency care system to respond for surge capacity for mass casualty and disaster. If on Wednesday afternoon we had had another van or school bus crash, only the dedication and commitment of the nurses and physicians would have taken care of those patients, because we had no room.

You know about that. You know about that because of some of the hearings that have taken place, that emergency care cannot respond. We don't have the capability to do it, we don't have the capacity to do it.

The other one that I think is quite frightening that the Institute of Medicine discovered is the workforce issues. If you look beyond the emergency department, there is a tremendous crisis developing on the surgical side to staff the in-house care that must take place after the emergency department.

One of the biggest things that we revealed is, in fact, after the emergency physicians resuscitate, it is, in fact, in these emergencies many specialists, cardiologists, and surgeons that are called to render care and complete care

within the hospital. The shortage of physicians and specifically surgeons that are responding to--and in the future as we try to cope with caring for about 80 million boomers, the shortage of surgeons is a profound thing in this report and needs to be addressed.

Thank you, Mr. Cummings.

Mr. CUMMINGS. Thank you very much.

[Prepared statement of Dr. Schwab follows:]

******** INSERT 1-A ********

Mr. CUMMINGS. Dr. Johnson.

STATEMENT OF RAMON W. JOHNSON

Dr. JOHNSON. Mr. Chairman, members of the committee. I want to first start by giving you an idea of my practice environment because I don't work in an inner city or a highly urbanized area. I work in a suburban emergency department that sees approximately 45- to 50,000 visits a year. We also function as a satellite children's facility, so we see-- approximately 40 percent of our volume are children.

I want to tell you that even in our sleepy suburban community, which I believe is typical of almost every community of America outside of the urban setting, I am in an environment that continues to be understaffed; we are underfunded, we are overworked, overwhelmed and overcrowded.

I want to address each one of those things for you. First of all, let me give you a story. It was interesting listening to Dr. Schwab talk about his experience. My experience is a little bit more profound than that because one day when I was working in the emergency department, a frantic mother brought in a child who was choking to death and was blue, and I did not even have a single bed available in my emergency department.

I debated for a few seconds, should I just put the child on the floor in order to try and open the airway? Did not even have a bed. And fortunately, because of the dedicated staff that we work with in our emergency departments, nurses, technicians, they were able to scramble a patient out of a bed and pull the bed over to the middle of the emergency department hallway where I pulled an apricot pit out of this child's trachea.

It struck me then and there when I looked up, and you kind of are adrenalinized at that point--you look up and see about 30 people looking at you, most of them are patients, some of them sitting with their gowns that are kind of open in the back, so it makes for an interesting sight as well.

I am here to tell you that even in my sleepy community of Mission Viejo, California, a suburban area, there are days when I don't have adequate resources to take care of patients.

One of the big problems that we are facing, I think, in this country is an explosion in the volume of patients we are seeing. In my area, for example, we have had a tremendous growth in population because of construction, and I understand that we are not the only area of the country that is seeing that kind of explosion, but one of the problems that we are seeing is the lack of infrastructure to help support that explosion in population growth. So as a result

we are confronted with the issue of overwhelmed, overcrowding every day.

We have a situation where we also have patients that are literally living in our emergency department for more than a day at a time. We have psychiatric patients sitting in our emergency department because we cannot get resources to them or there aren't beds in my immediate area to send those patients to.

Most people have this misunderstanding about overcrowding in emergency departments. I would like to dispel that myth once and for all here in this committee. Overcrowding in emergency department is not due to patients who have minor problems coming into the emergency department, it is due to patients who are sick, sitting in beds in my emergency department when there are no beds, no capacity in the hospital to get them upstairs. So I can't get new patients back into my emergency department.

That means that I have to contact my charge nurse and let her know when I don't have any bed any longer because they are full of inpatients in my department. I have to let her know the ambulances cannot come here. So that means although we are a cardiac receiving center, we have a cath lab available 24 hours a day to take the sickest cardiac patients in my community, I cannot get them into my hospital because I don't have a bed for them. So I have these

tremendous capabilities, tremendous talent, tremendous dedication, and I cannot get these patients to my facility to take care of them.

All I ask of you, all I ask of this committee and of the Federal Government is to help me do what I do best, and that is save lives and take care of patients. I cannot do that unless we have the resources.

I think the Institute of Medicine report laid it out very clearly, that we are underfunded, we don't have adequate resources. We are talking about a surge capacity; there is no surge capacity left within our hospital environment. By the way, my hospital is located approximately 30 minutes north of a nuclear power plant, and I can guarantee you if there is anyplace that needs surge capacity, it is my facility. It just does not exist.

Let me summarize by saying the American College of Emergency Physicians has over the last few years brought this to the attention of everyone we could possibly bring it to. We have had a rally on the lawn of the Capitol, had surveys that have been put together, we have even introduced a bill, the Access to Emergency Medical Services Act of 2007.

I know this is an oversight committee, but the fact of the matter is that we are making every effort to try and come to solutions that will help solve this problem. But, once again, my sleepy community town is, I think, average America,

and if we are seeing the same problems that the urban and suburban environments are seeing all over this country, then I think we should all be very, very afraid of what is happening. I think we really need to do something, and do something quickly. Thank you.

Mr. CUMMINGS. Thank you very much, Dr. Johnson.

[Statement of Dr. Johnson follows:]

******** INSERT 1-2 ********

Mr. CUMMINGS. Dr. O'Connor.

STATEMENT OF ROBERT E. O'CONNOR

Dr. O'CONNOR. Thank you very much, Mr. Chairman. I was struck by the opening comments that I heard several of you make, Congressman Davis, Congresswoman Watson, and Cummings. I agree with everything you said, and I am struck by the uniformity of recognition that our health care system, our emergency health care system, is in a state of disarray.

I look back at my own career. I have been in practice for over 20 years. I have been involved in the medical direction of prehospital care for just about as long; the instruction of prehospital care providers perhaps longer. I wanted to try to tell what my views were about how we have gotten to the place we are at today.

What I have seen throughout my career is tremendous strides in care. We take care of patients with myocardial infarction, heart attack, right now who we used to have no other treatment options other than to provide comfort measures only and not truly offer definitive care. We have made tremendous strides in trauma care, in stroke care, and the list goes on.

However, we are hampered by our ability to provide that

care. We have state-of-the-art technology, and yet we are practicing in a non-state-of-the-art environment where patients who are just hapless bystanders witness things that perhaps they should not see in a crowded emergency department environment.

The conditions in an emergency department, we have the tools to provide the best care that we can. The environment is so crowded that it sometimes creates a major obstacle to that. I look back on my career with EMS and prehospital care, it was sparked by funding that goes back really into the 1970s, prompted by trauma and the neglected diseases of modern society. Over that time the initial funding was at quite a high level. In 2007 dollars, it is about 1.5 billion. It was $300 million at the time. That since has dwindled. While a solution to the problem is not to throw money at it, I do think increased funding for EMS would be one possible solution.

The second part is to look at some of the funding agencies that provide care for EMS and to see how best to spend that money. If you look at certain EMS programs, the rural EMS grant program exists to support training and equipment for smaller communities; that has since been eliminated in funding. If you look at the Trauma Systems Planning grant, that also has been eliminated. The EMS for Children has to continually fight for funding year in and

year out, and it is only through the focused effort of Members of Congress that these programs have sustained funding from year to year.

Regarding one of the recommendations from the Institute of Medicine report, it was to establish a lead Federal agency, I have some comments in my written testimony regarding that. There currently exists the Federal Interagency Committee for EMS, which is the ideal body, really, to look at how to establish a lead agency. I think it is essential that we have a lead agency in the Federal Government, one to champion EMS causes.

If you go back to the fall of 2001, September 11th specifically, the public concern over our preparedness for terrorism, mass casualty events resulted in funding for police and fire and other agencies. EMS was notably absent from that funding pool. While I strongly believe that we need to have public safety--strong public safety resources such as police and fire, I also think that EMS is in a unique position where they work at the intersection of public safety plus public health. In fact, it is the integration of public safety with emergency health care.

So in closing, I would like to thank everyone for your efforts. We in emergency care take pride in what we do. We, I believe, provide excellent care to patients. We are somewhat hampered by the resources we are given and the

demands on our time and effort. If we are given the opportunity to and the resources to improve that care, we will welcome that opportunity. So thank you.

[Prepared statement of Dr. O'Connor follows:]

******** INSERT 1-3 ********

Mr. CUMMINGS. I want to thank all of you for your testimony. We will go into questioning now, and we will stick by the strict 5-minute rule.

I would like to ask the question of all three witnesses. Since back in 2002 the Congress has appropriated some $2.7 billion to the Department to improve the ability of communities to respond to emergencies that cause mass casualties. According to an analysis prepared for this committee by the Congressional Research Service, critics have charged the program over the years with lacking sufficient focus to adequately direct funds in meaningful directions, and with failing to assure that emergency health care services will be available consistently across jurisdictions.

Has billions of dollars spent by the Department to enhance--that's HHS--to enhance surge capacity for bioterror attacks and other mass casualty events made any difference in your daily practice? Dr. Schwab, we will start with you.

Dr. SCHWAB. Thank you, Mr. Chairman.

It's an interesting thing, if you look at the IOM report and some of the data we looked at, of all those billions and billions of dollars, if I can track this back, only 4 percent ever went actually into the States to look at EMS or look at preparedness.

In response to your question has any of this money affected myself or our trauma center or the emergency

department, the answer is categorically no. I don't think we could track a dime into the actual practice at bedside for making our lives better.

Dr. JOHNSON. I would have to also say no, Mr. Chairman. I sit on our advisory committee for HRSA funding for trauma preparedness in California, and I can tell you that while my hospital bought a tent, it doesn't help my day-to-day ability to take care of patients in the emergency department who are sitting there waiting for a bed upstairs.

Mr. CUMMINGS. Dr. O'Connor.

Dr. O'CONNOR. Of the money you cited of the bioterrorism program, less than 5 percent has gone to EMS during that time period.

Mr. CUMMINGS. Dr. Schwab, you describe the situation has steadily worsened over many years. The crisis has been extensively documented in academic studies, the news media and even the Department's own reports. From your perspective what, if anything, has HHS done to address the problem?

Dr. SCHWAB. I think one of the most important things that I think they have done is they have listened. I wish I could say they have reacted. On the other hand, I have been in this business now for 30 years. Twice during that 30 years I have seen Federal legislation that was directed specifically at emergency, EMS and trauma, and then within a few years I have seen actually that appropriation go away,

which means that they had money, we used it effectively, it went away, and we can't make the sustained type of efforts.

I was very heavily involved in the late 1980s and 1990s with HHS in designing the model trauma plan. That was 3 years' funding that was subsequently taken away through appropriations, and that whole effort failed, and honestly, all of our work really went up in smoke at that time.

So I think there is a complexity here that in order for the government agencies to respond, they have to have the money in order to do it.

Mr. CUMMINGS. A lot of people say that money is not necessarily always the answer. You hear that a lot up here. I have often argued that the most important thing is the effective and efficient use of the money. And so I think all of you all have talked about money, and I am just wondering what do you all see; and if you can wave your magic wand and you had the money, what would be the most effective and efficient use of it? I will start with you, Dr. Johnson, then go back.

Dr. JOHNSON. First, Mr. Chairman, I would like to say for at least my situation, unless my hospital wants to build more beds with that money, it doesn't really help my situation. More money doesn't help me personally in the emergency department.

What it may do, though, is allow me to get my orthopedic

surgeon to come in, because they won't come in to take care of patients who are underfunded. So it may entice them to come in and get my patients out of the emergency department a lot faster.

So unless my hospital wants to build more beds, it doesn't really help me. I will say there is no question in my mind that there are many nurses, for example, who I can't hire for my institution because the cost of living where I live is too high, and the salaries are too low. So if I had that pot of money, the first thing I would do it buy myself about 10 more nurses to be on staff every day because that would certainly help me take care of my patients in a more efficient way.

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Dr. JOHNSON. So, given that money, I would take care of that.

Mr. CUMMINGS. Dr. O'Conner.

Dr. O'CONNER. I think the best way to answer your question, the best way to spend money is to use it in a way where it is leveraged, where it amplifies the amount of money that we are spending. I think if you look at emergency care, systems of regionalization, a demonstration project in that area might be one such means to do that, to look at research so that findings in efficiency and effectiveness of care can be translated across the entire U.S. population, to look at a means of establishing best practices, whether it is through a demonstration practice as well.

But I would encourage, in terms of spending money--I mean, money, if there isn't enough, I think in terms of efficiently using it and safeguarding the taxpayers or the fiduciary responsibility, I think to look at the way to leverage the amount of money that is spent in terms of benefits to healthcare would be the way to go.

Mr. CUMMINGS. Dr. Schwab, I just want to go back to something earlier. You talked about the trauma system and how that might be helpful to what we are dealing with. Can you elaborate a little bit more on that?

Dr. SCHWAB. Yes, thank you.

Let me go back again, because I think it is important, because the staff has supplied you all with these references and our written comments constantly refer to the IRM report. The IRM committee worked for a year trying to find something that worked for a tactical solution, not a strategic solution, tactical. And what we did--and my colleagues to my left actually have already given you some of the successes, but the real success in organizing regional care and delivering one form of emergency care to life-threatened patients was trauma, trauma systems. This has been a three-decade effort led by the American College of Surgeons but endorsed by enabling legislation in some 40 States to create regional centers in which all patients whose life and limb are threatened are brought to those centers with waiting emergency physicians. They are effective, they are efficacious, and they are cost-effective.

And that is not me saying that or the OIM but, in fact, peer review literature. The most recent literature on that is in the New England Journal of Medicine in which a national study was looked at. Some of your States were included in this study; some were not.

In the entire national study population base it asked the question, what advantage to the patient whose life is threatened does a trauma system give? And it was a 25

percent reduction in mortality.

Now, we thought in the OIM that if we could use that as a blueprint and apply those components, efficient, effective regional not fragmented and accountable to an emergency care system, it would be a wonderful tactic to do it. And going back to Dr. O'Conner's comments, there is a strong recommendation in the OIM to provide money immediately to set up pilot projects and studies to study that as a regional emergency care system.

So I think the tactical solution is there in print, I think it is proven in that field of emergency care, and I think it is doable. And if you asked me what I would do with the money, Mr. Chairman, I would take it and I would fund those projects, those pilot projects, but I would make them accountable for what they are doing; and I would require them to report that not just to our government agencies but to you.

Mr. CUMMINGS. Let me ask one more question, and you all may answer this, too.

CMS has proposed a rule that would cut hundreds of millions of Federal Medicaid dollars from securing supplemental payment to hospitals and provide significant amounts of uncompensated emergency and trauma care. The purpose of these payments is to help these hospitals offset the financial losses they incur by providing those services.

Last month, Congress enacted a 1-year moratorium prohibiting CMS from implementing this rule. In this public notice about the rule, CMS officials say, and I quote, we anticipate the rule's effect on actual patient services to be minimal, end of quote. Do you agree with that?

Dr. SCHWAB. I don't agree with that; and I have to tell you, this was a real shocker to all of us. This was a shocker to me. Forty to fifty percent of all the patients that my emergency medical colleagues and I touch have their reimbursement essentially administered under CMS. To in any way give those patients less ability to pay us to cover our costs, many times not even cover our costs, to me is absurd.

What is interesting about this is CMS should be standing up for the consumer, the patient. And this month in Consumer Reports the back page is entirely dedicated to the consumer in what it calls the greatest crisis in the most threatening part of healthcare, emergency care, and it tells a consumer how to get through an emergency department visit. For us to think that we are going to lose more funding is absolutely absurd at this time.

Mr. CUMMINGS. Dr. Johnson.

Dr. JOHNSON. From what I understand, Mr. Chairman, it has been reported that hospitals lose more money on Medicare patients that come through the emergency department than some

other groups of patients. Fifty percent of hospitals report being in the red when they admit patients through the ED that are covered by Medicare. So I do think that CMS, if it can increase funding for those patients, it would actually assist in getting those patients into the hospital more effectively.

Mr. CUMMINGS. Dr. O'Conner.

Dr. O'CONNER. In terms of speaking to the hospital impact of those cuts, as it stands now Medicare's share of transports is greater than the share of payments. Medicare patients represent 40 percent of the total transports, while comprising only 31 percent of the revenue; and to have that money further cut would increase that gap accordingly. Providers pay substantially below their average costs even to provide routine transport. In fact, one other aspect of this is that in general pre-hospital care providers are reimbursed for transport only, not for the care or specific care that is provided. So I think those cuts would have a dramatic and deleterious impact.

Mr. CUMMINGS. Thank you.

Mr. Davis.

Mr. DAVIS OF VIRGINIA. Thank you. And thank you very much for what you do.

My son had a broken jaw in a Swarthmore-Haverford game. He broke his jaw in a baseball game; and, of course, he had to wait to get a physician that would do it because of tort

costs. But we took him to emergency, and I had my first experience with Pennsylvania's rules.

Let me ask you, in terms of magnitude, I am going to get an order of magnitude here in terms of the problems and how we can solve it here. Tort laws play a role, there is no question about that, in emergency rooms, mandated emergency care. We are serving people in many cases who are either here illegally or are uninsured and can reimburse nothing who play a role in this and are squeezing out other people who can appropriately pay.

We have certificates of need, limited beds, and try to allocate them in an appropriate fashion; and yet one of the problems I hear is that we don't have enough beds in some areas. But if they could get to appropriate certifications you could create more beds which would be able to alleviate moving people from emergency rooms to beds.

Federal reimbursability, which of course the private sector also pegs reimbursability now in some cases to Medicare, being very, very low, so even if you get a patient, the reimbursability of that doesn't always cover the cost. And when you add in the uninsured and everything else, it creates a huge problem; and the ability to attract and retain good people, whether doctors, where we still have a shortage, or nurses.

As you rank all of these, all of them have a Federal

component. What do we do? How important is each one or are some of them really red herrings or are they all important in terms of trying to get an understanding or our arms around this problem?

I'll start with you, Dr. Schwab.

Dr. SCHWAB. You are just picking on me because your son was playing in Pennsylvania.

Let me say this. They are excellent questions. Each on its own we could spend a fair amount of time, and I think you have to dissect and drill down and look at how it affects emergency care. I want to start with the first one you mentioned, if I could, sir, and that is tort reform.

One of the things in the last 10 years, including the major crisis in Pennsylvania trauma centers just a few years ago that Governor Rendell handled beautifully for us, and what was blamed for that was malpractice. If one tries to ascribe that tort reform will solve the crisis in emergency care, I would say that it is not fair. That is a much bigger issue. However, where it affects us is that there is no difference in our malpractice risk, our malpractice premiums, for delivering care to an emergency patient versus that patient in which you have established a doctor-patient relationship.

And what is interesting about that, again, in the report, if you look at it, the majority of the patients are

life threatened, many of which cannot speak for themselves, comas, hit in the head, having a heart attack or stroke. We can't get information about them. We have no information about them, yet we are required to treat within a matter of seconds.

I knew nothing about this man whose chest I had to open. I didn't know his allergies. I didn't know his medicines. I didn't know anything. I didn't know if he had diabetes. I didn't know anything. But I had to do something, as do my colleagues sitting next to me.

But what is interesting is my malpractice is exactly the same. I get no benefit for doing that. I get no recuse from that, and I am at extremely high risk if one goes ahead and tracks malpractice complaints into emergency care. They are very high.

So I haven't answered your question comprehensively, but at least your first topic, what we say in the OIM report is there needs to be a study done immediately to look at some way of relieving the physicians and nurses that are applying or giving emergency care. And by that we defined and said we should define what an emergency episode is and in that episode we should go ahead and look at how the government may recuse us from some of the malpractice burden we have if we truly are delivering life-saving care.

Mr. DAVIS OF VIRGINIA. Everybody thinks reimbursements

are low, and that drives a lot of this as well, the uninsured. I appreciate your answer.

Dr. Johnson.

Dr. JOHNSON. Some things they can do to help alleviate some of the problems, they are a very powerful organization because they hold the purse strings; and hospitals do whatever they can to try to get ahold of those funds. I think we can use its purchasing power to get hospitals to probably move patients upstairs by creating financial centers to reduce crowding. If hospitals achieve high efficiency and get patients out of there in an efficient way, they can be rewarded by CMS for doing that; and if they are not, they can also raise a big stink, so to speak, to be penalized for not moving patients out of ED.

For example, we have observation codes that CMS could also expand upon to provide additional funding where we can now put patients into areas of the hospital where we can observe them and not require full hospital admission. That actually might save money in the long run for the system.

Finally, I do think you probably are aware that there are many different types of patients that hospitals can put into beds upstairs. Some of those are nice elective surgeries where it is certainly predictable how long they will be in the hospital and how much it is going to cost them, and it seems CMS is more than happy to pay a certain

fee for those patients. But when you have an emergency department patient who is very ill, the hospital cannot collect enough money to cover their costs. So if CMS were to expand and prioritize emergency department patients over those nice elective, predictable patients, that actually might get patients into beds a lot more efficiently and open up the emergency department beds.

Mr. DAVIS OF VIRGINIA. Let me talk to you on the tort side, because Dr. Schwab makes a case. You probably know less about your patients than anybody else when they come in. You have to make life-saving decisions based on limited information; and if it is the wrong decision you are going to see it in court and you are going to have to revisit that. Is the standard pretty tough for emergency room? What has been your experience?

Dr. JOHNSON. To be perfectly honest, there is a tremendous amount of defensive type of medicine that is practiced in the emergency department. There are many things that we do knowing full well that we are just covering the base, so to speak, and probably not as important in the care of the patient. If I had some relief, some liability protection, I think that I could also practice in a more efficient way, absolutely.

Mr. DAVIS OF VIRGINIA. Thank you.

Dr. O'Conner.

Dr. O'CONNER. In terms of liability protection, many of the services are protected to the level of gross negligence, which maybe one such model is to look at emergency care in its total as a means to overcome this problem.

In terms of your question, there are staffing issues; there are hospital issues.

Mr. DAVIS OF VIRGINIA. Gross negligence made a much higher standard of negligence to show we give you some relief in not having to do some of these defensive mechanisms. Is there a consensus on that? That is an easier standard for you to operate under at least.

Dr. O'CONNER. It is, yes. I never would have thought that EMS pre-hospital work would be impacted by things such as nursing home placement, things on the other end of healthcare.

In looking at the cover that is now six years old, Crisis in the ER, and it really is a crisis in the healthcare system, I think our current admission and discharge process from the in-patient setting is broken. And it is reflected by the overcrowding stories that we have heard, it is reflected by ambulances that have to divert, thereby creating a problem in a second hospital that they divert to. Ambulance diversions are particularly problematic because they tend to cause a rapid downward spiral of the entire system in that region.

So I think, in answer to your question, it is not a simple thing to answer. I think that, as a first step, we may want to try to understand the problems a little bit better.

Mr. CUMMINGS. Mr. Yarmuth.

Mr. YARMUTH. Thank you, Mr. Chairman.

I want to get at that topic a little more extensively. I am trying to get my arms around--and I know it is hard to generalize across the entire country in all sorts of different communities--to what extent this is a total patient capacity problem and, therefore, more of a method of dispersion problem, as opposed to just an emergency room capacity problem. Dr. Schwab, do you want to start?

Dr. SCHWAB. Thank you.

Let me just say the difficulty here is--if I can just have you think about a large geopolitical area. So you have got a metropolitan service area, suburban area and a rural area. There is a certain number of hospital EMS units, emergency departments that render care for their citizens. There is no doubt that there is a disbursement or a fragmentation problem. And again in the report we identified that and said one of the things that could really help deficiencies is if we design this regional emergency care system that all components of that care system, the rural ambulance core up in the mountains versus the ones in the

city, are all talking electronically and in real time so that we can take people to where there are open beds. Thus the term regionalization.

But then there is also a problem in that what we have got to do is we have got to look at how those hospitals that are getting them, and especially if the patient needs specialized care, cardiac, neurologic, trauma obstetrical or pediatric, that those centers that function as the regional emergency care center are in fact enabled through proper funding and proper resources to be able to maximize their efficiency and be able to move patients through.

Dr. O'Conner just mentioned he never thought that the nursing home would affect the EMS. I can tell you every day we have now continuously dedicated very high-level nursing and administrators who are helping to get people out to skilled nursing facilities, rehabilitation so we can take people in. It is all connected, Congressman.

But I think what you have to look at is, again, how you might design this regionalized system which would help us disburse people better but not lose sight that not all hospitals can deliver all types of cares.

Mr. YARMUTH. To what extent--and maybe Dr. O'Conner can address this. To what extent do you believe that the competitive aspect of institutions exacerbates this problem?

I know in my community we have several very highly

competitive hospital entities who are--some, most not-for-profit now, but we know that means in the healthcare business mostly nontaxpaying, they don't make profits. I am curious as to whether you have done an analysis of how big a problem that is in this context.

Dr. O'CONNER. I can give you some examples.

Locally, we established a--again I won't name the locale, but we established a pre-hospital 12-lead program to identify patients with heart attack, with acute myocardial infarction in the pre-hospital setting so they could go to a place where they could receive angioplasty if necessary and found tremendous resistance from some of the smaller hospitals which utilized a potential comparative disadvantage for taking care of all patients, not just the heart attack patients.

I went back to them with data that showed how many patients this involved in such a small number and they were the types of patients that were being transferred out anyway by the hospital, so they were more accepting.

We started the program, and it has been very successful. I say this because if you can educate the administration of these other hospitals they will realize it is not really a competitive disadvantage, but what you are doing is saving a secondary transfer or taking patients who are too sick for that hospital or require services that could not be rendered

by that hospital.

Mr. YARMUTH. One quick question, and anybody can answer.

We talked about this regional approach, and I understand that would be very important here. To your knowledge, is any region or any community in the country doing a good job at this? Are there any models we can look at to try to roll out across the country?

Dr. SCHWAB. Well, I don't want to play to your chairman, but the model that actually occurs in the State of Maryland is probably an excellent model to look at. As far as trauma systems go, the model in San Diego. As far as models in emergency medical coordination, the greater Pittsburgh region are areas that are well-known.

To go back to the question how would you use your money, what we need to do is formally study those and see what the best practices are, again, for efficacy, efficiency and effectiveness and make sure that that is not just our feeling but in fact we can prove that to the country and to our citizens.

Mr. CUMMINGS. Thank you very much.

Mr. Issa.

Mr. ISSA. Thank you, Mr. Chairman.

Dr. Johnson, welcome. I apologize that I no longer represent Mission Viejo, but redistricting was not kind to me

in my loss of Orange County.

Governor Schwarzenegger has proposed in your home State, in our home State, a broad, sweeping universal coverage initiative that requires that employers either take fiscal responsibility for their employees or pay a 4 percent fee that would go into a pool to help fund those activities which are necessary as a result of their failure. And emergency rooms, obviously, become the first choice of people who have no formal health coverage.

In Orange County if, in fact, we were able to accomplish that through private means to ensure that every individual had either State coverage, if they were unemployed or indigent in some other way, or company coverage, back door, front door, depending whether or not an employer provided that care or paid the 4 percent, how much would that change what you see at the emergency room in yours and neighboring hospitals?

Dr. JOHNSON. That is an excellent question. Let me answer that by saying, since 1993, the number of patients visiting the emergency department has arisen to 115 million visits a year; and most of those visits are patients who are insured. They are insured. So it is not a question of not having funding and going to the emergency department because it is a place of last resort. It is a question of not having access to primary care capabilities within the community;

and, as a result, the emergency department becomes the facility where they are forced to go because they can't get in to see their physician. Or, worse, they go to see their physician who decides you must go to the emergency department. In that regard, whether there is a universal coverage in California or not, it probably would not change in our particular environment in Mission Viejo.

Mr. ISSA. So how do we reverse that? I realize it is a wealthy community in the center of the greater LA, Orange County, San Diego megalopolis. So if it can be fixed, and a suburban well-to-do neighborhood would seem to be the easiest place to fix it, how do we make those changes to get people to the front door of an urgent care or to the front door of routine medical treatment through a normal relationship and not at your emergency room door?

Dr. JOHNSON. Well, once again, given the reality that most of the patients who actually come to the emergency department are absolutely sick and actually need to be there, we actually see a very small volume of patients who actually have minor problems that really do not need to be in the emergency department. Unless we are willing to build another hospital in Mission Viejo, California, we are not going to solve the problem.

Mr. ISSA. When you say "sick," do you mean life-threatening, immediate injury, or--

Dr. JOHNSON. Life-threatening admission.

Mr. ISSA. And what percentage did you say that was?

Dr. JOHNSON. Between 20 and 30 percent of the patients who present to the emergency department there require admission.

Mr. ISSA. Twenty percent.

Dr. JOHNSON. Twenty to thirty percent.

Mr. ISSA. What about the 80 percent?

Dr. JOHNSON. I would say the remaining 70 percent, at least half of those patients require being seen in the emergency department and probably receive care within 2 hours.

Mr. ISSA. What did we do in our society that created this huge rise?

Dr. JOHNSON. Lack of primary care access is driving a lot of it. I think patients are waiting until they are sick before they seek healthcare.

Mr. ISSA. So they are insured, well-to-do, suburban neighborhood; and they are not going to primary care because there is no access.

Dr. JOHNSON. Correct. If you call your physician and say you need an appointment to be seen because I have a cough and they say I will see you 3 weeks from now, that doesn't work. Then you wait a week until you have pneumonia and then go to the emergency department.

Mr. ISSA. I guess I will ask one more time, because this is an area I want to show light on. It is your neighborhood that I missed. Because if anything can be fixed, it can be fixed in Southern Orange County because means are there. You are saying we need more doctors so doctors don't say come in 3 weeks. What really will change that. Do we need urgent care? Do we need community clinics? Tell me what we need in one of the richest geographic areas in the country that we don't have and why.

Dr. JOHNSON. There is no doubt the entire healthcare system is broken. I think all those things are possible solutions. I do think we can expand our emergency department capabilities to add more observation capability, for example, and keep patients out of the inpatient service but require some prolonged level of care, perhaps in between the inpatient service and the ER.

Mr. ISSA. The day before yesterday I was with Michael Moore, the maker of Sicko; and the group I was with, I was the only person that wanted to preserve the private care system. Everybody else in that room, from Mr. Conyers on down, they wanted to have a single-payor, government-driven system. And I have to ask you, do you know of a single-payor, government-led system that would fix this? And what is that model, if one exists?

Dr. JOHNSON. I think any model that we create in the

United States of America will be unique to this particular country. I don't think we can look to other models to be the only model that is available. I think we will have to try to find our own model that will work for most of our citizens.

Mr. ISSA. Anybody else want to weigh in on that?

Dr. SCHWAB. If you'll think of Philadelphia as Orange County.

Mr. ISSA. I love Philadelphia. You had a great convention for us there, and I was there just a few weeks ago. Except for the heat, the humidity, if you are on the 19th floor and you look out, it does look like San Diego.

Dr. SCHWAB. In short, I don't think one solution fits all.

I will go back again to the OIM report. We looked at this. And specifically what we said with no doubt, including one of our recommendations, is we have to increase access to primary care in all aspects of the population. Because, according to the analysis, if you look at those 114 million ED visits, a huge percentage of those, maybe not where Dr. Johnson practices, are for non-life-threatening emergency chronic care conditions for people who can find care in no other area. And in Philadelphia, in our hospital, that is a huge part of our emergency medical faculties' burden.

Mr. ISSA. Thank you, Mr. Chairman, for the indulgence.

Mr. CUMMINGS. No problem.

Let me just say this. As I listen to the testimony, it is frightening. When you think about an area like, for example, where you operate Dr. Johnson, to have the kind of problems that you just stated is amazing. Then I guess it quadruples in an area where you are from, Dr. Schwab. Is that a fair statement?

Dr. SCHWAB. Yes, it is.

Mr. CUMMINGS. Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman.

John Maynard Keynes once said that we are all the slaves of some defunct economist. I would like to suggest that we may be somewhat the slaves of the major Federal intervention in this area in the last several decades, the EMTALA law. When you see graphs like the ones we have been presented with where patient demand is going up, up, up and the number of emergency rooms and emergency capacity is going down, down, down, there is a fundamental problem. Because any regular economic system when demand goes up, supply goes up. So, thinking strategically for a moment, I think that what we really need here is a recognition of the role that money plays.

Mr. Issa questioned why in a rich community there is a shortage of primary care. Well, it is pretty well-known, at least at the elite medical schools, no one wants to be a primary doctor, because being an emergency doctor pays much

less than being a specialist and the work is often more difficult and carries other risks.

You get what you pay for, and you don't get what you don't pay for. You also don't get what you mandate without funding. And if we had a third panel of hospital administrators, the people who actually allocate resources between the grass roots and 60,000 feet, I think most of them will tell you, whether a nonprofit or for-profit, that the ERbusiness is a very bad business to be in.

That is why new-fangled hospitals, specialty hospitals oftentimes don't even include an ER. And that is why, in a celebrated case that I am surprised hasn't been mentioned, in a Texas specialty hospital they had to call 911 from the hospital because they had no emergency capacity within the hospital.

So it seems to me that if you look at programs like Medicare or Medicaid the truth is they really don't pay enough for the services received, and they haven't for years. And everybody knows that, but we don't do anything about it. And a couple billion dollars here or there isn't going to solve the problem because the problem is so immense, you know, these specialty problems, because bioterrorism or things like that are fashionable at the moment, they are little more than Band-Aids for the needs that you have.

When the government wants to tackle the problem, it can.

None of you are old enough to remember the old Hill-Burton hospitals that were built pretty much nationwide after World War II because we needed more hospital capacity.

Well, today, we need more ERcapacity. And especially that surge capacity that many of you have alluded to is extremely expensive. Because, by definition, surge capacity is not used a good bit of the time; and you have to pay for all these resources to be on hand when they are not used.

But think of this analogy. With fire protection, it costs you more the farther you live from a good fire department. We may be reaching the time where health insurance will cost you more the farther you live, the less able your local ER is. Because I think Dr. Schwab mentioned a 25 percent risk or increase in mortality if you don't receive proper emergency care.

Dr. SCHWAB. Proper trauma care.

Mr. COOPER. So these are serious issues that will take far more than this committee's resources to deal with.

I would like to suggest that fundamentally it is an economic problem; and yet physicians, others who are not trained to think in those terms--but solving them I think will take an economic solution.

So I have used up my time, Mr. Chairman, but it is more of a statement than a question, anyway.

Mr. CUMMINGS. You actually have about a minute, because

the timer malfunctioned.

Mr. COOPER. Timer malfunction. Well, I would welcome any response that you all have. I just say it is more of a statement than a question.

Dr. O'CONNER. If I may very briefly, I think your comments are right on target. We are in many ways--I am very comfortable with EMTALA, because any patient who comes in I have to say that is the way I would like it. I look at the curves in the reports.

Mr. COOPER. EMTALA has two parts, the requirement that you see and then also no pay.

Dr. O'CONNER. Yes. I was going to say when EMTALA was first enacted I was talking to a leader in the health insurance field who said I am not paying for a medical exam. There is no reason I have to. That has, of course, softened somewhat. I was struck by that stance.

I think if you look at the number of visits in emergency care, in many ways, we are victims of our own success. A patient can get a very elaborate work-up in a very brief period of time. A similar work-up as an outpatient would take days to weeks. So I think that is part of the explanation for demand. Even if we had something along the lines of universal health coverage, demand would still be quite high. That would be my opinion.

Mr. CUMMINGS. Mr. Murphy.

Mr. MURPHY. Thank you very much, Mr. Chairman.

Thank you all for being here today.

I spent 4 years as the chairman of the Public Health Committee in the State of Connecticut; and part of the reason that I sought a seat here in Congress was that it was pretty apparent that this wasn't going to be a 50-State strategy, that there needed to be a central solution to the issue of overcrowding in the ER.

I want to ask the three of you sort of an unfairly simple question. It strikes me, as we are talking about potential solutions here, that there are sort of three areas in which you can focus your efforts.

First, you can focus your efforts on trying to prevent people from getting to the ER in the first place, either through greater access to primary care or through trying to broaden those that have insurance.

Second, you can focus on the ER itself, greater resources there, greater coordination between sites.

And, third, as Dr. Johnson noted, you can expand the ability to move patients out of the ER. You can broaden and expand the capability of hospital inpatient services, i.e., sort of open up the potential to move patients out more quickly.

I guess it would be helpful for me at the very least to get a sense of how you might prioritize those three

approaches. If we had to focus in one place first, second and third, preventing people from getting there, making the process itself in the ER more efficient or, thirdly, trying to open up capacity to get people out of the ER, how might you recommend us approaching that? Or is there a fourth that I am missing?

Dr. JOHNSON. I would certainly recommend the final recommendation which would be to open the capacity by inboarding patients in the emergency department. By inboarding and opening beds in the emergency room, all of a sudden you open the problem of ambulance diversion. You basically allow patients to be seen in the ED. If they have no access to primary care, we are more than happy to take care of them there. Most emergency departments have figured out that if patients have minor problems they can wait in the waiting for who knows how long or be seen in another area where minor care cases can be seen efficiently. But once you at least have bed capacity in the emergency department you can do what you are there to do, which is to save lives; and getting those boarded patients out should be the number one priority, I believe.

Dr. O'CONNER. I would agree that the third priority is the key of increased capacity. Because, without it, it doesn't allow for improved efficiencies within the department.

I think a lot of the inefficiencies that occur in the emergency department now are directly attributable to patient boarding hours, where staff will take care of patients who are normally in the inpatient setting.

As far as keeping patients who don't belong there out, I think just by waiting times and the crowding issue, we sort of do that already. We have looked locally at some of our EMS transports, and patients with seemingly minor complaints such as a headache self-triage with higher queuing if they call EMS. Or if they come to the emergency department, as opposed to an urgent outpatient clinic, they tend to be sicker, tend to have a more serious illness than if not.

Mr. MURPHY. Let me ask one last question, and that is the issue of psyche patients. One of the greatest capacity issues for inpatient beds in Connecticut is our lack of inpatient psyche beds, adult psyche beds in particular. How much of a problem right now is the lack of capacity on the back end to get psyche patients, both juvenile and adult, out of the ER and into a more community based system of care or an inpatient system of care?

Dr. JOHNSON. A single word: Huge. In my department, for example, one to two patients a day that come into my department are psychiatric patients. Even after we have done all the medical screening, they could potentially sit in my emergency department for a period of time from hours to

literally up to 24 hours and supposedly would get admitted into our hospital if there is bed capacity. But they have actually lived in our emergency department for a couple of days before we can get psychiatric personnel to come out and evaluate them to find a bed to place them.

Sometimes there may not be a bed to place them; and, as a result, they will have to stay in the emergency room if they are a true high risk before we can actually stabilize them or have an evaluation of them to be seen or to be sent home or to another institution.

So psyche patients are a huge problem. I would love to talk to you after the hearing on ways we might be able to solve that, but this is a huge problem confronting emergency rooms all over the country now.

Mr. CUMMINGS. Thank you.

Let me ask a question quick. If you had to relate our emergency systems using hospital terms like "intensive care" or "a critical condition"--you know the various terms you all use--how would you all describe it?

Dr. SCHWAB. I would say it is life-threatening or resuscitating on a day-to-day basis, and it is going to die if we don't fix it. I don't know if that is hospital terms or not.

Mr. CUMMINGS. It sounds pretty hospital terms to me, but it sounds almost like funeral home terms, too.

Dr. SCHWAB. Let me just go on and say I meant what I said before. If it wasn't for the dedication of the nurses, the paramedics and the physicians that struggle with this on a day-to-day basis, this system would have broken already; and that was the conclusion the Institute of Medicine's report.

Mr. CUMMINGS. Dr. Johnson.

Dr. JOHNSON. Mr. Chairman, I believe that you are looking at the proverbial canary in the mine right now. You are looking at him face to face. Because I am here to tell you that when I take my last breath in that emergency department it will be when that system completely falls apart, and I am on my last breath right now. So we are the canaries, the emergency physicians and the nurses and the personnel. I have had some of my best nurses leave my department, which is I believe one of the best departments in California, to go to other areas of the hospital like the cath lab where they can get paid the same salary for half the work.

Dr. O'CONNER. In terms of what is acceptable to the staff, situations that used to be considered bad days, tough days at work are now routine; and the threshold to which some of the days rise is appalling.

Mr. CUMMINGS. Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman.

I had the privilege for almost 20 years to represent as my prime clientele community hospitals in Maryland and the region, probably 25, 30 hospitals over the course of that time. So this problem is one that I am very familiar with from all sides, and it is almost impossible to overstate it. You are trying your best here to do it in ways that will get our attention, which I think you have, but hopefully a broader attention.

Dr. Schwab, you said "the patient may die" when asked to assess this system using those kinds of terms; and, Dr. Johnson, you said that the system--you are holding on before the system completely falls apart. What does that look like? What does this system look like when it dies, where it completely falls apart? What is the prospect down the road that we can look back later to the testimony in this hearing and say, well, this is not a surprise to anybody. I mean, we predicted this would happen.

This is the fundamental human problem of if A, then B, and if B, then C, but for some reason we can't get it together to have a minimal amount of foresight. So what does it look like when the system dies?

Dr. SCHWAB. Let me tell you about my Wednesday afternoon, which is a pretty typical day. What you probably don't know is that we are the most frequently closed trauma center in the State of Pennsylvania. We are closed nine

times more than any other trauma center in the State because of volume. So I see this doomsday picture you are asking me to give. I see it momentarily.

Because what happens is we close, ambulances are diverted, ambulances go to other centers, some are not trauma centers, there are no surgeons waiting. And ultimately what happens, I think, if we can ever prove it and would dare to prove it, is patients die. If the emergency system falls apart, rather than that being episodic throughout a day, it is going to be continuous; and it will be some kind of terrible movie that I don't want to ever think about.

But it is happening now in our largest cities and even some of our suburban areas. It happens. People are diverted. And there is now an excellent study to show that people, other patients don't do well with diversion. They die while they are being diverted.

There is also now studies, one of which is now coming out of the University of Pennsylvania, which shows that if simultaneously on an overload condition everybody is busy, you are doing major trauma cases and yet another cardiac code comes in, there is data to show that those patients don't do as well. Why? Because everybody is busy.

Think of O'Hare International Airport on Friday afternoon, a terrible thunderstorm and all flights are cancelled, what it is like. It is mayhem.

Mr. SARBANES. You conjure up an image in my mind where, ultimately, diversion is straight to the morgue. That you are going from one hospital to one hospital to one hospital and you can't get in; and eventually, you know, you just pass it by and you go straight to the morgue. That is what I am hearing here.

Dr. JOHNSON. In your scenario, what would probably happen is that a patient would stay in the ambulance until they reached a point where they would die, and then the ambulance would have the ability to upgrade the patient to a code status and go to the nearest facility, regardless what the status would be, whether they are open or closed. So patients eventually do have a finite period of time which they can ride around in the ambulance.

I will tell you what will happen in your scenario. It will be a very slow, incremental collapse of the system, beginning with the loss of subspecialty capability. So neurosurgeons, orthopedic surgeons, hand specialists, they would eventually be gone from those facilities. And what would happen is you would lose them in your rural areas, for those who have that specialty backup already, and then you would lose them from your suburban areas and consolidate them in fewer and fewer facilities, leaving more and more facilities without any subspecialty backup. Which means if you come in with something other than something that would be

under the capability that I can handle as an emergency, if you require plastic surgery or if you need a hole drilled into your skull to relieve pressure from building, that would not happen and you would, of course, then die in my facility because I would not be able to transfer you anywhere and would not have the specialty backup in order to take care of you.

So that is how it would happen. The lack of subspecialty services would mean that patients would die at the institutions they were at.

We would foresee increasing ambulance diversion to the point where you would have some facilities that would have ambulance diversions continually. I know in my area there was a rule in the Los Angeles area that if you are on diversion for so many hours you have to be off an hour before you can go back on. So it would be a diversion, off diversion, diversion, off division.

Mr. SARBANES. You are describing an emergency diversion system, not an emergency care system. I appreciate you being candid about this. Let's talk about a solution.

I am out of time. Thank you, Mr. Chairman.

Mr. CUMMINGS. Thank you, Mr. Sarbanes.

There are a lot of people dying, aren't there? I am basing it on what you all just said. There are people dying that don't have to die.

Dr. SCHWAB. That's correct.

Dr. JOHNSON. Yes.

Mr. CUMMINGS. Ms. Norton.

Ms. NORTON. Thank you, Mr. Chairman.

This is an important hearing. I am here not only as a member of this committee but as a member of Homeland Security Committee. I am here also as a representative of a big city in the post-9/11 period, one might say of a big city in the post-9/11 period where you have to think about EMS. And there is a lot of thinking about it, but I don't think enough thinking about what the Federal Government's responsibility is to EMS ambulance services.

Taking a point you make, Dr. O'Conner, in your testimony about the funding of EMS ambulance services. Looking to more than 30 years ago, 1973, this was a clear priority because we funded $300 million to advance EMS services nationwide, is that correct?

Dr. O'CONNER. Yes. That was in 1973.

Ms. NORTON. Now, in real terms, you show a kind of priority. In real terms 1973, that amount of money would be $1.5 billion today.

Now, let's look at what you are coping with now. The block grant program, the whole thing has been block granted. That happened in 1981. What we are seeing is the devolution of this whole mission. As I understand it, the block grant

program provides these EMS services to only 16 States and only $8 million. We are talking now the equivalent of $1.5 billion 30 years ago. $8 million out of $9 million that we appropriated, but only $8 million of it for EMS services.

Now, as I understand it, the Bush administration wants to eliminate the block grant altogether. Now that would mean the $8 million would be gone, would it not?

Dr. O'CONNER. Yes, it would.

Ms. NORTON. In 2006, the committee notes that the Bush administration zeroed out the small community ambulance development and trauma EMS programs that was once run by HHS. We are awfully concerned here about isolated rural communities, and without community ambulance service I don't need to tell experts like yourselves what the effect of that would be. Now the only HHS program that I could find that still supports EMS services at the Federal level is the EMS for children, called the EMSC program, is that not correct?

Dr. JOHNSON. That is correct.

Ms. NORTON. Now the signature issue for this administration is homeland security. We are talking about emergency services. This gets to be very serious. In the last three budgets, we could not find--what we did find was the administration had proposed to zero out even EMSC programs, is that not correct?

Dr. JOHNSON. That's correct.

Ms. NORTON. We talk about a nonexistent program. Can you explain how over 30 years we have gone from a priority for EMS services through the Federal Government to essentially the decline and fall of such services? I mean, how could that happen? Have States been clear about the importance of these services?

In post-9/11, Dr. O'Conner, you are from Virginia, close to where we had the worse trauma, second only, of course, to New York, how could this disconnect continue to get to this point?

Dr. O'CONNER. There has been a slow decline over 30 years. The initial money started up what we now know as pre-hospital care and EMS. That was largely successful. In fact, it was money that most would argue was extremely well spent. It allowed the establishment of State EMS offices and really created the medical care that we know today in pre-hospital care.

What has happened since then is there has been a transition of funding to different areas that has resulted in it becoming a very easy target to zero out the EMS programs. I would just hope that the administration would reconsider some of these.

Ms. NORTON. So if it wanted to eliminate something and you had calls on the money, was this considered more a State issue and not a Federal issue, do you think, so the money

could be stolen from here as opposed to other places?

Dr. O'CONNER. I think some of it has to do with the fragmentation of the EMS. There is not a single go-to lead agency that can oversee where the money goes.

Ms. NORTON. Would folding it into the block grant--was that the beginning of the end of the program?

Dr. O'CONNER. In retrospect, yes. I didn't know that at the time.

Ms. NORTON. Do you think that this program should be a stand-alone program?

Dr. O'CONNER. I think that all of emergency care would fair better as a stand-alone program. This is not just about EMS. It is about everything we do in unscheduled care for emergency problems. I think if the sum total of emergency care were a stand-alone agency, it would help for sure.

Dr. SCHWAB. If you are asking me about EMS alone, I think, once again, my comments have always been to look at the emergency care system comprehensively, a lead agency or a coordinating body with the authority of responsibility and continuous appropriations to help us solve these problems.

Ms. NORTON. And you think EMS would receive the proper priority within emergency care?

Dr. SCHWAB. I absolutely do. In the OIM report, we actually call on that. One of the three reports is about emergency medical services, and we need to fund them

adequately to do their job.

Mr. CUMMINGS. The gentlelady's time is up.

Let me say as we summarize and we move onto our next panel, the gentlelady, when she opened her questioning, she talked about homeland security. And I was just curious, if we had a Madrid level bombing today in D.C., for example, what would happen? Would we be able to take care of folks?

Dr. SCHWAB. America has always been good, Congressman, at rising to the occasion, no matter what it was. So would we be able to take care of them? The answer would be, we would. The question is, who would suffer? Because we have to put all of our resources taking care of those that are involved with that type of bombing. Where would we divert our ambulances, where would the children go, and where would the routine myocardial infarction, heart attack, stroke victim go while we were overwhelmed with that?

Mr. CUMMINGS. So there is no capacity, really, no extra capacity.

Dr. SCHWAB. There is no extra capacity. That is very clear. It is frightening because, because of our emergency departments being overloaded with routine patients and trauma patients and whatnot, it occurs on a day-to-day basis already. So adding on a disaster like that from would just overwhelm the system.

Mr. CUMMINGS. Dr. Johnson.

Dr. JOHNSON. I would echo that as well, Mr. Chairman. I think that in the beginning when the Federal Government created monies to be used for bioterrorism protection, what it didn't do was figure out we would be much more at risk of a routine bombing. As we started down the road of buying tents and preparing for pandemic flu, we have yet to deal with the day-to-day environment of not having enough trauma surgeons, not having enough resources in our everyday emergency department that is already overwhelmed.

Dr. O'CONNER. At this time of day in every emergency department in the United States there is no capacity, so completely overwhelm the system.

Mr. CUMMINGS. Thank you all very much. Your testimony has been chilling. It is very, very helpful. Thank you very much.

We'll call our next set of witnesses: Dr. Kevin Yeskey and Dr. Walter Koroshetz.

As you all come forward, I just want the committee to know the committee also invited Dr. Leslie Norwalk, the Acting Administrator of the Center for Medicare and Medicaid Services for EMS to testify on behalf of her agency. She has declined to appear citing schedule conflicts. She also has declined to send any other CMS official to represent her agency.

This is highly unfortunate and, frankly, inexplicable

and inexcusable. The programs administered by CMS play a major role in the financing of our healthcare system, including medical care and emergency care. Indeed, all patients admitted to a hospital through the ER, over three-fifths are covered by Medicare or Medicaid. Because lack of adequate financing is one of the factors contributing to the Nation's emergency care prices, the testimony of CMS is critical to a full assessment of the Department of Human Health and Human Services' response to the emergency care crisis.

RPTS CALHOUN

DCMN HERZFELD

[12:16 p.m.]

Mr. CUMMINGS. Our staff was informed that Ms. Norwalk's schedule did not permit her to attend. However, CMS has 4,328 full-time employees. It is difficult for us to understand why she could not be with us today. So the Office of the Assistant Secretary for Preparedness and Response, which is represented here today, has only 222 full-time equivalent employees. This is just 5 percent of CMS's staff capacity.

I have shared these concerns in Ms. Norwalk in a letter sent earlier this week, and ask unanimous consent a copy of that letter be included in the record at this point. Without objection, so ordered.

[The information follows:]

******** INSERT 3-1 ********

Mr. CUMMINGS. This afternoon the committee will send a letter to Ms. Norwalk posing a set of questions regarding her agency's response to the emergency care crisis. We look forward to complete and truthful responses to these questions by the close of business on Friday, June 29th. I ask unanimous consent that those responses be included in the record as well. No objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. CUMMINGS. Thank you very much, Doctors. Would you please stand.

[Witnesses sworn.]

Mr. CUMMINGS. We will first hear from Dr. Kevin Yeskey, the Director of the Office of Preparedness and Emergency Operations and Acting Deputy Assistant Secretary in the Office of the Assistant Secretary for Preparedness and Response at HHS.

STATEMENTS OF KEVIN YESKEY, M.D., DIRECTOR, OFFICE OF PREPAREDNESS AND EMERGENCY OPERATIONS, ACTING DEPUTY ASSISTANT SECRETARY, OFFICE OF THE ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND WALTER KOROSHETZ, M.D., DEPUTY DIRECTOR, NATIONAL INSTITUTE OF NEUROLOGICAL DISEASES AND STROKE, NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF KEVIN YESKEY

Dr. YESKEY. Thank you, Mr. Chairman, members of the committee, for the invitation to speak to you today on such an important topic, one in which the Office of the Assistant Secretary of Preparedness and Response is extremely interested and engaged.

I am Kevin Yeskey, a Board-certified emergency medicine physician, a former U.S. Public Health Service Officer and the Director of the Office of Preparedness and Emergency Operations within the Office of the Assistant Secretary for Preparedness and Response at the Department of Health and Human Services.

The Office of the Assistant Secretary for Preparedness

and Response is relatively new, being created by the Pandemic and All-Hazards Preparedness Act passed in December of 2006 establishing a lead Federal official for public health and medical preparedness and response within HHS. The Assistant Secretary for Preparedness and Response, ASPR, serves as the principal advisor to the Secretary of Health and Human Services on matters related to Federal public health and medical preparedness and response activities to national disasters.

Additionally, the responsibility of the ASPR include leading the Federal public health and medical response to acts of terrorism, natural disasters and other public health and medical emergencies; two, developing and implementing national policies and plans related to public health and medical preparedness and response; three, overseeing the advanced research and development and procurement of qualified medical countermeasures; four, providing leadership in international programs, initiatives and policies that deal with public health and medical emergency preparedness and response.

In short, the ASPR is responsible for ensuring a one-department approach to public health and medical preparedness and response, and leading and coordinating the relevant activities of the HHS operating divisions. As a result of many changes, including the passage of the Pandemic

and All-Hazards Preparedness Act, the Office of the Assistant Secretary for Preparedness and Response is forward-leaning and results-driven, and in just a short time since the enactment of the Pandemic Act has created the Biomedical Advanced Research and Development Authority; has completed transfer of two programs, a National Disaster Medical System from the Department of Homeland Security and the Hospital Preparedness Program from the Health Resources and Services Administration; and has announced a National Biodefense Science Board, again, all completed since January of 2007.

We are also committed to the use of evidence-based processes and scientifically founded benchmarks and objectives standards called for in the law under the National Health Security Strategy. By utilizing this approach, OASPR will assure consistency in the preparedness efforts across our Nation, ensure greater accountability of local, State and Federal entities, and provide for a foundation for improved coordination.

The IOM Future of Emergency Care report represents an objective assessment of the status of our Nation's overall emergency care, as we have already heard. Recognizing the importance of these reports, HHS convened an internal work group to examine the 22 recommendations that were specifically directed at HHS.

We evaluated the initiatives, and the work group

suggested a strategy to address those concerns. The work group comprised senior-level representatives from the relevant operating divisions and staff divisions of the Department, to include the National Institutes of Health, the Centers for Disease Control and Prevention, the Center for Medicare and Medicaid Services, the Food and Drug Administration, the Agency for Health Care Research and Quality, the Health Resources Services Administration, the Assistant Secretary for Health, and the ASPR.

The work group met regularly in 2006 and 2007, and the ASPR and I were briefed about the work group's progress. In evaluating the recommendations, the work group concluded there were three consistent items. One was the creation of a lead agency for emergency care within HHS to encourage efforts directed at daily emergency care issues, while also supporting the Federal Interagency Committee on Emergency Medical Services. The second was a unity of effort within HHS to promote clinical and systems-based research; and, finally, to further promote greater regionalized approaches to delivering daily emergency care.

The Institute of Medicine also held regional workshops to discuss these findings and recommendations and to encourage an open dialog with involved parties. The final capstone workshop conducted here in the National Capital included the participation of the ASPR.

As already noted, we have undertaken initial steps to better understand the IOM report recommendations, and we have initiated steps within HHS to implement them. ASPR is also creating an administrative element within the Office of the Assistant Secretary for Preparedness and Response that will promote coordination and unity of effort across the Department's emergency care activities.

In closing, OASPR will continue to provide leadership in this area, fostering a departmentwide approach to the Nation's emergency care issues.

Again, thank you for the invitation to speak today.

Mr. CUMMINGS. Thank you very much, Doctor.

[Prepared statement of Dr. Yeskey follows:]

******** INSERT 3-2 ********

Mr. CUMMINGS. Dr. Koroshetz.

STATEMENT OF WALTER J. KOROSHETZ

Dr. KOROSHETZ. Thanks very much. It is a pleasure to talk to you about the NIH efforts in emergency research.

The emergency conditions that threaten patients with risk of their life and risk of their quality of health are exceedingly important to the NIH, and much of our effort goes into trying to find better treatment for these patients, and I would ask you to think about our efforts in terms of a pyramid where at the bottom we have the basic research issues that then go up higher into the translational research issues where what we discover from the basic, can it be applied to disease process. And at the final top of that pyramid is the effort to get this out to patients and actually try in patients to see if it really helps them.

I would say that this has been the motive of research at NIH, and it has actually, I think, led to significant improvements in the care of emergency patients. I would say that at the current time the difficulties you heard in the first panel, they are impediments not only to patient care, but also to research on this high end of the pyramid where it is much more difficult now to be able to translate these new

discoveries into better care in that environment where people are so hard pressed, very hard to ask them to do research on top of taking care of patients.

So I would just emphasize what you heard this morning is affecting the research in emergency care as well as the patient care.

In response to the IOM report, the NIH put together a Trans-NIH Emergency Medicine Task Force comprised of representatives from over 23 institutes. We are now involved in doing a targeted internal review of our research portfolios and trying to get at the key questions that need to be addressed to improve emergency care of patients, what are the real big questions that need to be answered.

Doctors also met with leaders of emergency medicine and asked them to come up with the same type of analysis, what are the big questions that need to be solved in this area to improve patient care. Because it is very multidisciplinary, these problems are--some of which are very high-level neurologic problems, cardiac problems, it requires coordination throughout the NIH, and after the NIH there has been a much greater emphasis on doing this kind of coordination through the Office of Portfolio Analysis and Strategic Initiatives. So I think we can come up with a trans-NIH approach to these problems that arise from our internal review and from discussions with the outside

experts. As mentioned before, the NIH has participated with the major groups at HHS.

In terms of just a couple of examples of what came out of our institute, the Neurologic Institute, lots of things that are real emergencies that need to be taken care of quickly like strokes, head injury, and we have, for instance, set up networks of emergency physicians to try to do trials and get new treatments in the emergency scenario out to patients quickly. We have stroke centers throughout the country where emergency medicine has to be a lead organization. We are trying to train emergency physicians in these centers to become experts in stroke care delivery.

And even in the Washington area, the NIH Intramural program has gone into emergency rooms in different hospitals and offered stroke and imaging expertise in the emergency setting. The NHLBI has had similar efforts with the Resuscitation Outcomes Consortium, the Heart Attack Alert Program, and NIGMS with research and training programs in trauma.

So, in summary, I think that the NIH is very successful at coming up with new discoveries that will impact the care of emergency patients. Our bottleneck may be at this point of testing in the environment, which, as you heard today, is somewhat chaotic, and we are certainly interested in working with the Department and the Assistant Secretary of

Preparedness and Response to improve delivery.

Mr. CUMMINGS. Thank you very much.

[Prepared statement of Dr. Koroshetz follows:]

******** INSERT 3-3 ********

Mr. CUMMINGS. Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman.

Dr. Yeskey, I am interested in knowing more about this $2.7 billion of resources that has been committed since 2002 to the Hospital Preparedness Program, and I guess what is remarkable is the testimony we heard from the prior panel was pretty uniform in saying they don't really see much evidence of impact from expenditures to that program.

That is consistent with my own experience when I worked with community hospitals post-9/11, and certainly post-2002 when these dollars became available, where, for the most part, absent the occasional grant opportunity, they were not able to perceive any kind of coordinated effort to improve disaster preparedness at their level.

And I understand the program is now within your jurisdiction or oversight, and I wonder if you could speak to why it is that so much money has been spent on this, and yet in the field the practitioners who are on the front lines don't have a perception that it has made any kind of a measurable impact on improvement.

Dr. YESKEY. The program in its transfer coming over needs to be enhanced in its ability to assess the impact that it has had. We know we can do a better job of assessing both the weaknesses of the program thus far, as well as some of the successes, and there have been some successes. The

program initially was set up to provide hospital preparedness for the bioterrorist scenarios rather than the day-to-day surge capacity issues that we heard about today.

But there have been successes. Hospitals have developed command-and-control systems that enable them to integrate better into a community's response plans with EMS, law enforcement. They have developed interoperable communications so they can help in a systems way route patients in an event so they have a better way of getting the patients to the care they need. Those are just a few examples of that.

I think we need to look a little bit harder at how we can improve how moneys are being spent using more effective performance measures, being able to describe what exactly we want hospitals to do and to measure that. The money we give in a hospital preparedness program goes to the States. It doesn't go directly to the hospitals, it goes to the States, and they distribute that money to their hospitals and health care facilities rather than going to the hospitals directly.

We do in this year, in this upcoming grant program have a competitive piece as directed by the Pandemic and All-Hazards Preparedness Act where money can go for the development of regional coalitions of hospitals, and that money will go directly to those coalitions rather than to the State; however, those coalitions need to be integrated into

an overall state plan. And we hear that from the States from time to time, that they want to make sure that they understand what their coalitions are doing so it fits into the overall State preparedness plan.

Mr. SARBANES. So it sounds from the get-go they needed more accountability as the money was being passed down the line, which ultimately that accountability comes back to those who are originating the grants and the money that is flowing. So that is the Federal Government's responsibility, if it is going to dispense $3 million, to make sure as it is meted out, it is being done in a judicious way.

Let me ask you real quick before time runs out, we heard a lot of testimony about what some viewed a tactical response to the emergency care situation, I view perhaps as it being strategic as well, and that is to set up these regional networks of response, emergency care, and I was glad of the mention of what has been accomplished in Maryland, which I think is a model with the NIMS model and the shock trauma and so forth.

I assume you see great possibilities in that approach, and that many of these dollars would be directed towards trying to facilitate that kind of thinking and modeling.

Dr. YESKEY. We support the regional--coalition of the regional models of emergency care.

Mr. SARBANES. Thank you, Mr. Chairman.

Mr. CUMMINGS. Thank you very much, Mr. Sarbanes.

Dr. Koroshetz, in the IOM report on emergency care, the committee recommended, and I quote: The Secretary of the Department of Health and Human Services should conduct a study to examine the gaps in opportunities in emergency and trauma care research and recommend a strategy for the optimal organization funding of the research effort.

I am very glad to learn from your testimony this morning that the Department has organized a Trans-NIH Emergency Medicine Task Force. When can we expect the task force's recommendations?

Dr. KOROSHETZ. My understanding is that we are currently in the process of doing the internal review and the fingerprinting of the research that is going on now, and that should be done by the end of this year, along with the consultation with the outside groups about where they see the gaps matching up with our assessment. And so we think the beginning of next year we would have the final.

Mr. CUMMINGS. Now, let me tell you this, that Mr. Waxman and this committee, we are going to hold you to that, so when you get back to your shop, and there is something different, would you let us know that? And I hope staff will make that a part of our questions, because one of the things that we are trying to do is what we found a lot of times is we will get answers, people tell us they are going to do

things, the next thing you know, time passes by and it is 2 years later, whole new group of Congressmen, whole new committee, and it sort of slips under the rug. This is something that we cannot afford to let that happen. So we are going to hold you to that.

Dr. KOROSHETZ. I understand.

Mr. CUMMINGS. Dr. Koroshetz, in your written testimony you state, and I quote: The structural issues in the U.S. health care system do not fall within the purview of NIH.

If that's true, then where should the doctors like those on the first panel turn for the research they need to help them improve the organization and delivery of emergency care?

Dr. KOROSHETZ. Well, I think we would say that the NIH is going to be most effective at determining what is the best therapy for a patient and actually improving what that therapy is. But the issues that you heard about this morning are so complicated with regard to the finances, the regional organizations, specialist involvement, that going into those areas would really detract of our mission of making these therapies available.

I would caveat that by saying that certainly we will put an emphasis into bringing the therapy to market and trying to break down the bulwarks that prevent that from coming to market, but it is probably something we can't do alone, that we need to do with people who are interested. The Brain

Attack Coalition is a nice example. So we came up with a new stroke therapy, but it requires a great deal of new work being done in emergency departments to deliver that therapy, and you heard how strained they are.

We started a coalition with emergency physicians, EMS providers--

Mr. CUMMINGS. Let me ask you this. I just want to make sure we are able to end this hearing so we don't have to hold you up for another 2 hours or hour and a half. Let me ask you this: Would the Agency for Health Care Research and Quality have jurisdiction over this, be helpful with this?

Dr. KOROSHETZ. I think in the past that they have looked at delivery of health care and outcomes related to how care is delivered.

Mr. CUMMINGS. So you would recommend that?

Dr. KOROSHETZ. I think from the standpoint of the questions about those which relate to what is the best therapy versus how it is actually proportioned, I think that the AHCRQ, it may be more in their ballpark in terms of how things are delivered.

Mr. CUMMINGS. You realize that AHCRQ, their budget is more than $300 million, or a little more than 1 percent of your agency's budget; do you know that?

Dr. KOROSHETZ. Yeah.

Mr. CUMMINGS. Let me leave you with this. I heard you

talk about getting therapies, I guess, into practice. One of the things that, if we listen to the testimony today, what we heard was those therapies are nice, they are important, but they are not getting to people in many instances because people are dying.

Dr. KOROSHETZ. Because of the overcrowding issue.

Mr. CUMMINGS. Yes. I was just sitting here thinking anybody in this room could possibly, God forbid, have a heart attack right now, and although we may have all the research, we have done all the things we are supposed to do, given money to NIH, and then because of overcrowding, they will die. Even the gentleman, Dr. Johnson I think it was, from one of the more affluent areas, people in his district are dying.

And so it just seems to me that we can do better. And it is a shame and very upsetting that CMS did not appear here today. I think that that is one of--when you have got close to 4,250 employees, and you can't find 1 person, and it is your responsibility to address this issue, and you don't show up, you are a no-show, that is a major, major problem. This committee is determined to get Dr. Norwalk here and to figure out what is CMS doing about this problem.

Ladies and gentlemen, I move that the Members have 5 days to submit questions and comments. With that, the hearing stands adjourned. Thank you very much.

[The information follows:]

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[Whereupon, at 12:38 p.m., the committee was adjourned.]

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